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The Corruption Game: Health Systems, International Agencies, and the State in South Asia

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Abstract

Drawing on ethnographic material collected in Pakistan, India, and Nepal, this paper analyzes patterns of corruption in vaccination programs in South Asia. Corrupt practices—which required substantial work—were deeply shaped by both the money and systems of accountability of the global health system. Bilateral and multilateral donors provided substantial funding for immunization programs across South Asia. International agencies and governments instituted systems of accountability, including documentation requirements and a parallel UN bureaucracy in problematic districts, to try to ensure that health workers did what they wanted. Some immunization program staff skillfully bent these systems of accountability to their own ends, diverting vaccination funding into their own pockets. Corruption operates not in opposition to the official rules, but in spaces opened up by them. These practices sometimes transform Weber's rational bureaucracy into a sophisticated game with many players, whose aims are more complex than the stated goals of the bureaucracy.

My co-workers are selling vaccines meant for the health post across the border, in the Indian market. We used to have rabies vaccine, but they sold it. I heard they made 40,000 or 50,000 rupees [$400 or $500]. The thing is, the people who are selling these vaccines, they are actually giving diesel, petrol and money to the powerful people who are in a position to take action against them.

Everyone here tells the people in power that things are all right, but things are not all right.

--government health staff, rural Nepal

Those superior people who sit in air-conditioned rooms, they have no interest in actually eradicating polio because they are making so much money from the polio program. I speak up, but tote ki awaaz naqqar khane men kaun sunega? *[Who will hear a parrot raising its voice in a drum pit?]*

--government health staff, urban Pakistan

Corruption is a ubiquitous topic in discourse about government health systems in South Asia. Government health staff and patients alike discuss corruption, dissect it, defend it, decry it, and analyze it. Pregnant women and their families weigh the cost of bribes in government hospitals against the cost of fees in private ones. Low-level government health staff gossip about who is making money from various projects. High-level government and UN officials blame corruption for the failure of grand plans (Figure 1).

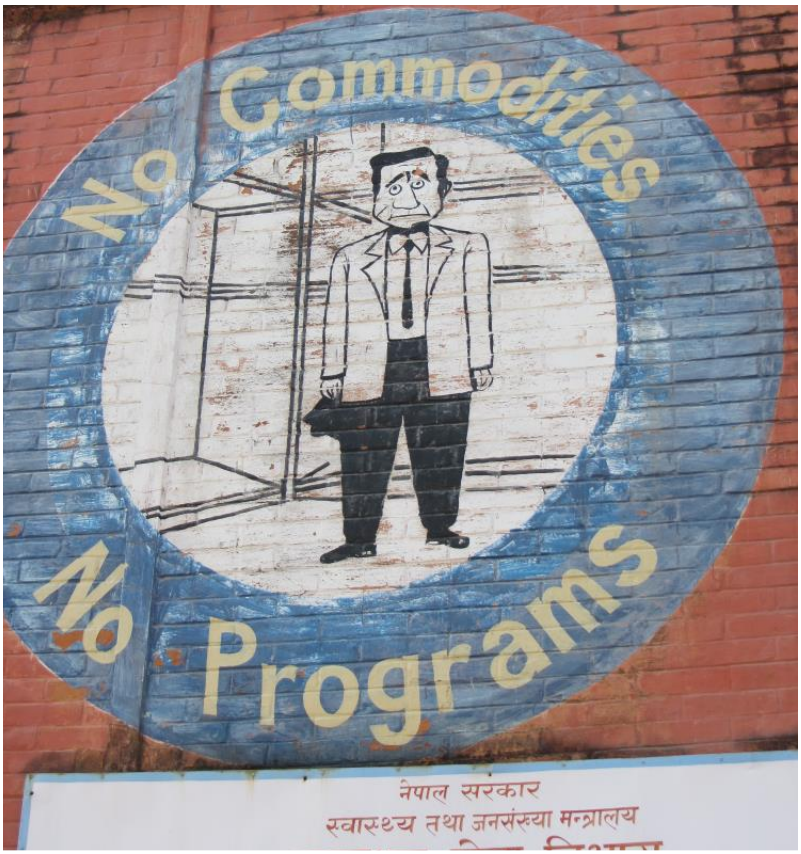

Figure 1. Sign painted on a government health post wall in Nepal

Compared to this constant and often strident popular discourse, the anthropological voice on corruption in health systems is muted. Corruption as a concept appears throughout the ethnographic literature on health systems, but it remains under-theorized. Recent notable book-length ethnographies mention corruption, sometimes in passing (C. Wendland 2010; Livingston 2012; Rosenthal 2017), but do not engage deeply or theoretically with it. Similarly, corruption is mentioned, but not explored and analyzed, in many ethnographic articles focusing on health systems (Pfeiffer 2003; Oni-Orisan 2016; Dao and Nichter 2016; Abadía‐Barrero 2016; Ellison 2014; Herrick and Brooks 2018). When anthropologists do

engage with the concept, they frequently focus on discourse and metaphor rather than practice (eg. Pop 2016; Kalofonos 2010).

There are several notable exceptions, papers that explore practices of corruption in more depth. Cathleen Willging and Elise Trott (2017) critically examine a corruption controversy surrounding behavioral health services in New Mexico. Dan Smith (2003) describes how the perks associated with family planning training sessions can be used to strengthen patron-client relationships in Nigeria. Seyyed-Abdolhamid Mirhosseini and Hossein Fattahi (2010) explore the ways that Iranian doctors in public hospitals justify referring patients to their private practices. Gillian Le (2013) describes the trade in medical certificates in Vietnam. And, in a wonderful paper that never once uses the word "corruption," Michael Oldani (2004) examines gift exchanges between drug reps and doctors in the United States in the 1990s.

These articles show that acts of corruption always occur in a cultural and bureaucratic context; the structures of health system funding and administration—in addition to cultural models of ethical behavior—will drive the shape that corruption takes. Here, drawing on ethnographic material collected inside vaccination programs in Pakistan, India, and Nepal, I analyze patterns of corruption in health systems in South Asia. Corrupt practices—which often require substantial work—are deeply shaped by international aid, structured by both the money and systems of accountability of the global health system.

Corruption and Anti-Corruption

Within the growing literature on corruption in anthropology, there is a body of theory that is very useful in looking at the dynamics of aid-supported government health

programs. This literature argues that both corruption itself, and anti-corruption efforts, are political, molded by the power structures of a given society (Nuijten and Anders 2017). Within governments, both corruption and efforts to curb it are often shaped by interactions between national and local actors whose agendas may conflict (Torsello and Venard 2016). Corruption (a word I am using here as an analytic category, not a moral one) is a set of practices embedded in the power relations, and power struggles, of political entities at multiple levels.

Sarah Muir and Akhil Gupta show that corruption, and attempts to end it (what they call "anti-corruption") are intertwined and mutually constitutive. They explain, "each anti-corruption effort transforms the logic of corrupt practices and each corrupt practice calls forth new kinds of anti-corruption measures" (Muir and Gupta 2018, S7). Thus an analysis of practices of corruption must be about politics and power: what are the aims of different actors in a political system, and how do these aims shape both practices of corruption and efforts to stop it?

Exploring these questions in government health systems in South Asia requires examining power relationships and flows of money at national and international levels. International health aid is given in a context where discourses of transparency and accountability are promoted by organizations such as the World Bank and the IMF, and where corruption may be constructed as connected to "national culture" (Muir and Gupta 2018; Tidey 2018; Nuijten and Anders 2017). Elites in Kathmandu in the 1990s, for example, drew on development agencies' idealized visions of impartial bureaucracies when labeling Nepali systems of patronage and reciprocity as corruption (Adams 1998).

Thus bureaucratic rules and practices of corruption, Aradhana Sharma argues, "are inverted mirrors of each other, deeply intertwined and co-constitutive: the one is a symbol of rationalized liberal modernity and the other a symbol of its dangerous, unwieldy underside" (Sharma 2018, S72; Nuijten and Anders 2017). Since the shape these inverted mirrors take is highly context-specific, most anthropologists rely on emic definitions of corruption (Torsello and Venard 2016; Muir and Gupta 2018).

At high levels in South Asian immunization programs, "corruption" referred to people breaking programs' official guidelines to achieve their own ends. In high level discussions, corruption was frequently lumped into the category "management issues," an umbrella term which also included incompetence, laziness, and lack of consequences for doing shoddy work. From the point of view of high-level immunization planners, all of these behaviors had the same result: low vaccination coverage. And, these phenomena were related: for example, if an immunization manager had gotten their position because of their connections to a powerful politician, there might be little incentive for them to work very hard.

South Asian languages, like many others across the world, distinguish between a variety of practices of corruption: as just one example, in Urdu, there are different words for bribes (*rishvat dina)* and for giving preferential treatment to one's friends and relatives (*safarish karna*). Some practices, particularly those involving gift exchanges within a bureaucrat's social networks, are tolerated or even mandated in local moral economies (Jauregui 2014; Hull 2012). However, as the quotes that open this article indicate, not all practices of corruption are universally supported by local moral economies in South Asia—

rather, the acceptability of such practices is often in the eye (and the political and social position) of the beholder.

Anthropologists have explained such practices in health systems across the world with reference to the low wages of civil servants (Streefland 2005; Mirhosseini and Fattahi 2010). But this explanation is incomplete. Well-paid bureaucrats engage in corruption too. Situating these practices within the politics and aid flows of the health system corruption/anti-corruption complex allows for richer explanations.

Examples from Ethnographies of Vaccination

The material in this paper is drawn from four ethnographic research projects in Pakistan, India, and Nepal spanning the years 2007-2012. These projects were ethnographies of vaccination programs, conducted in collaboration with other anthropologists and skilled research assistants. Corruption was not an explicit research focus, but forms a common thread in the ethnographic material across these different times and places.

These research projects were designed to follow the process of policy formulation and implementation: how policy created in places like the World Health Organization in Geneva and the Bill and Melinda Gates Foundation in Seattle gets interpreted in national capitals and put into action by local workers. Investigating these links between the local and the global required multi-sited ethnography (Marcus 1995) in a number of locales, including communities on the receiving end of immunization programs, the local bureaucracies carrying out disease surveillance and immunization campaigns, and the offices of immunization officials in national capitals and international agency headquarters.

In these studies, we "followed the project" (Markowitz 2001), analyzing the progression of policy and money across these sites. Rather than performing a comprehensive ethnography at each site, the aim in these projects were to create rich, nuanced ethnography of the South Asian immunization bureaucracy—a complex entity that exists across many locales.

Because vaccination is among the most cost-effective of all health interventions, and because it targets child mortality, it is a priority in the field of global health. Donors and agencies including Gavi (the Vaccine Alliance), UNICEF, and the World Health Organization (WHO) provide both funding and internationally-designed protocols for immunization programs. As a result, their basic structure is remarkably consistent across Pakistan, India, and Nepal, and indeed across Sub-Saharan Africa as well. Disease-specific vaccination campaigns target measles and polio, and routine vaccinations are given at government health posts.

Both operational indicators and vaccine coverage are globally monitored. In theory, this data is collected and maintained by governments. In areas where governments fail to do this, there is a parallel health bureaucracy made up of UNICEF and WHO employees. Their job is to provide "technical support" to government health staff—meaning in practice that they both collect data and attempt to ensure that immunization activities are carried out according to plan.

When I, a white American woman, arrive at a district health office with documents giving me permission to observe practices, I am generally expected to act as other foreigners in that context do: as an international consultant who assists in vaccination program monitoring and data collection. The role of international consultant, on paper, is

to “support” district health systems. In practice, consultants report conditions on the ground to WHO, UNICEF, and national government officials.

This role works well for participant observation in the complex politics and power dynamics of district health systems. As international consultants are expected to identify issues like data falsification, they are frequently central participants in accusations of corruption—founded or not.

In the research projects this paper draws on, my collaborators and I conducted several hundred interviews in total with government, UNICEF, and WHO health staff at levels ranging from Community Health Worker to international policymaker. We also conducted participant observation in vaccination campaigns as well as national- and international-level UN and government bureaucracies. Most of the ethnographic material presented here is from my own fieldnotes, with some details supplemented by collaborators’ fieldnotes and audio recordings; the majority of the interviews were carried out by collaborators and research assistants.

Details of location, time, names, and personal characteristics have been camouflaged in the vignettes that follow. I have chosen not to specify the location—even the country—of these examples, for several reasons. The first is a matter of anthropological ethics. I would like to avoid negative repercussions for the officials who gave me permission to do research. The second is that the social structures at play were stunningly consistent across Pakistan, North India, and Nepal. Differences in funding notwithstanding—vaccination programs in Pakistan and Nepal were largely externally funded, while the Indian government paid for most vaccination expenditures itself—the global socio-cultural

context of vaccination programs drove their structure much more strongly than local cultural variation.

The examples I present here are particularly obvious instances of corruption. They are not typical of South Asian immunization programs; I could easily provide a wealth of counter-examples of districts whose staff were committed to accountability and the provision of quality services.

At the same time, these examples are also not completely atypical. They represent particularly striking examples of patterns of behavior apparent across the ethnographic data from a variety of times and places.

Bureaucratic Cultures in South Asian Health Systems

The practice of making money from bureaucratic posts has a deep history in South Asia. British civil servants in the East India company in the late 1700s, faced with extremely high mortality rates that meant death was more likely than return to England, "sought to make as much money as possible as quickly as possible" (Barrow 2017, 57). They used the advantages of their East India Company positions to engage in private trade, demand and keep rents for East India Company property, and amass fortunes collected from wealthy Indians who were dependent on them (Barrow 2017; Nechtman 2010; Dirks 2009).

The extreme wealth of returned East India Company employees created a scandal in Britain. As a result, the British Parliament began pulling the East India Company under its control, and a focus on written documentation as a symbol of transparency and accountability arose (Barrow 2017; Dirks 2009; Raman 2012). The resulting bureaucracy, in which "supplicants arrived in droves only to find pen-wielding scribes and fixers

managing their precious access to the distant European gentlemen" (Raman 2012, 23), was the antecedent to the modern South Asian bureaucratic office, characterized by teetering mountains of papers piled on shelves and bureaus. Then, as now, a bureaucrat's ability to extract resources from a South Asian bureaucracy depended on their ability to create the paperwork legitimizing the scam (Raman 2012; Hull 2012).

Many modern South Asian bureaucrats are well aware of this colonial legacy. For example, an email sent by the Pakistan Ministry of Health to all health division employees exhorting them to avoid "the commonly diagnosed maladies of corruption, inordinate delays, red-tapism, indifferent attitude, unscrupulous integrity, etc," included a copy of a speech given by Muhammad Ali Jinnah, Pakistan's founder. That speech, given a year after Independence, encouraged civil servants to cast off the behaviors of colonial administrators. "I know we are saddled with old legacy, old mentality, old psychology and it haunts our footsteps," Jinnah had said, "but it is up to you now to act as true servants of the people."

Power, Money, and the Aid System at the National Level

Corruption and anti-corruption in South Asian vaccination programs were shaped by the structure of the global aid system. International agencies used aid money to get governments to adopt the programs and policies they wanted; they also instituted systems of accountability to try to ensure that this money was being used according to their wishes.

In her classic book *Policies, Plans, and People,* Judith Justice showed how health policy in Nepal in the 1980s was shaped heavily by international funding and its associated

policy guidelines. Donor demands for accountability led to a small army of highly-paid international staff in Kathmandu, who "often become more involved in carrying out projects than they might ideally want to be" (Justice 1986, 32). By the 1990s in Kathmandu, Vincanne Adams elaborates, pressure on the Nepali government to adopt internationally-designed projects and guidelines

> came to be seen as a form of external profiteering, keeping foreign development agencies and their local national advisors in business without keeping them accountable to local recipients… [The national aid coordinating committee] was said to have become a means of ensuring that privileges for development contracts went to those connected to the palace [and] that appropriate amounts of "commission" (*baksheesh)* were distributed to Nepali governmental agents (Adams 1998, 55).

Although the actors have changed somewhat, these underlying dynamics remain. The governance and funding structures of global immunization programs lead to policies that are often more heavily influenced by donors than by local governments (Buse 2004; Muraskin 2004). In the years covered by the studies described here, India's government, in an effort to reduce the power of international agencies, decided to fund much of its immunization programming itself—although international guidelines remained in place, and WHO and UNICEF staff were still stationed in problematic districts. In Pakistan and Nepal, however, immunization programs had more substantial external funding. Although vaccination in these two countries was officially a government responsibility, at administrative levels some immunization programs were run in practice by WHO and UNICEF staff.

For the most part, this situation was accepted by national-level actors, with an occasional grumble by UN staff that they were doing all the work, and an occasional grumble by government staff that international agencies were setting all the priorities. In

many cases, this system worked reasonably well, with both government and UN staff playing parts in increasing vaccination coverage across the region. Occasionally, however, these tensions boiled over.

At a national meeting in one country, there was a dispute over funding and staffing in several districts with high rates of vaccine preventable disease. A UN agency had been providing additional vaccination funding to the government in these districts, but had recently decided to stop doing so. A representative of that UN agency explained in the meeting, "we realized that despite the fact that we were providing resources, they were not being managed correctly, so we have to say sorry, enough is enough."

The government immunization manager for these districts responded to this allegation of mismanagement by complaining about the UN agency's hiring practices for its staff. The UN agency had placed staff of its own in the districts in question, and they had been hired without input from local government officials. The government manager said, "We are thankful to [the UN agency]. They are supporting us. They should support us and they should assist us, but not they should dictate us... How will they assist and support us when they are not reporting to us and when we are not on board when [their staff] were recruited?"

A powerful national-level government official added, addressing the UN agency representatives: "Personally, I will express my views here very clearly, I am not satisfied with the situation… You can have your recruitment processes but the government has to be there. Government is in the decision making position, and also the government needs to know who is the member of the team. We cannot have isolated teams doing whatever they want. We want everybody to follow the same plan, so nobody can be outside the plan."

This exchange is a relatively rare case in which the underlying power struggles between UN agencies and the national government of this country were laid bare. UN agencies and international donors provided funding with the expectation that government officials would use that funding to meet their immunization targets. This was described as donor "support" for vaccination programs in this country.

In this case, however, the narrative broke down. A UN agency pulled the funding to select districts where there were no results, revealing an underlying truth: that the agency provided funding not only as a "support" to the government, but also as a way to get the government to do what it wanted them to. Government officials at the local and national levels seized this moment to complain that the UN agency was not "supporting" them but was "dictating" to them. This statement was, in certain respects, true, and it was also strategic.

Attacking the UN agency's hiring practices was a way to attack its power at the district level. WHO and UNICEF directly hired huge workforces, accountable directly to them, across South Asia as a way to provide "technical support," but also oversight, in districts with high rates of vaccine-preventable disease. In general, UN agencies wanted local staff outside the government system because their own staff could be held accountable for performance in a way that government staff were not.

Most UN employees were not from significantly different backgrounds than government officials—many had been government employees in the past—but their structural position, in which they received a salary several times larger than that of government officials in return for ensuring accurate documentation and high vaccination coverage, placed them at odds with government staff aiming to game the system. These

staff, as well as hundreds of international consultants deployed across South Asia, were a key way that UN agencies attempted to influence practice at the district level. "Lots of internationals in a broken situation increase your span of control," a WHO official in Geneva explained to me.

These workers spent their time attempting to ensure that the data provided on immunization forms reflected reality. They went door-to-door, speaking with mothers about whether their children had been vaccinated and cross-checking parental report with the information on official records. They intercepted government vaccination staff in the field, examining how much vaccine had been used and calculating whether that was consistent with the number of children these workers claimed to have vaccinated.

At the District Level: The Creative Scams

Case 1: Nakshapur

Nakshapur was a city of contrasts. Many of its residents were wealthy, and property values were high. Residents of beautifully appointed homes joked that the city they lived in was "only 15 minutes from Asia"—meaning that their wealthy enclaves felt more like Europe or the US. Their children were nearly always fully vaccinated, not by the government system, but by their private pediatricians.

Squeezed between these mansions were Nakshapur's *katchi abadi*s: tent colonies sharing vacant lots with trash heaps, or temporary straw huts in areas slated for development. These were the homes of the underclass: day laborers, balloon sellers, snake charmers, and rag pickers. Scabies and lice were the constant companions of the children in

these settlements; of more concern to international agencies, only a quarter of them were fully immunized.

The quality of the government health system in this area was not of much concern to the wealthy residents, who relied on the city's world-class private doctors and private hospitals. And, there was little political incentive to provide high-quality services to slum populations, who the city government was frequently attempting to evict. But, the low rates of immunization in the *katchi abadi*s were seen as a problem by international organizations.

I arrived at the city government offices early on the morning of a door-to-door vaccination campaign to find Dr. Rashid, the local WHO staff person, seated in his large and dingy office behind a huge desk. Dr. Sharma, a doctor from a nearby country who had been posted to the city by the American Centers for Disease Control and Prevention (CDC), was on a dilapidated couch. Dr. Rashid printed out supervisory assignments for the three of us.

My printout listed a man named Kashif as supervisor of the area I was assigned to check. I dialed his number to ask where I could meet him. The man who answered the phone said that Kashif had resigned his job and left for Saudi Arabia two weeks ago. I reported this information to Dr. Rashid, who said that this was impossible, as Kashif was at a training yesterday. I should go to Kashif's health post, Dr. Rashid said, and see if I could find him there.

When I reached the health post, the diffident doctor told me that Kashif had gone somewhere where there was "no phone signal" to monitor vaccination work. He gave me a note, apparently written by Kashif, saying he would be unreachable. The note included a different mobile number. I tried calling, but that phone was off.

Finally, to get rid of me, the doctor sent the health post *chowkidar* (guard) to show me the areas where Kashif would be working. We drove for half an hour into the hills nearby (all with excellent cell coverage). In these arid areas outside the city, we could see for miles, and there were no populations of any kind—not even nomadic herders.

As we drove around, the *chowkidar* explained to me what was happening: "they fabricate workers," he said. "They put extra populations and extra workers on the plans, and then they pocket the fake workers' pay."

Indeed, the maps that Kashif had submitted to Dr. Rashid featured lavishly drawn communities in areas that in fact were unpopulated desert. This creative exercise in population creation required more initiative than Kashif's routine work, which consisted of day after day of verifying that children were vaccinated, and filling out the same tally sheets. Given the low rate of pay for workers, the amount of money Kashif gained from this exercise was less than $30.

In the evening, following government and WHO regulations, the campaign supervisors and government officials held a meeting to discuss the day's work. Before the meeting, I talked with Dr. Rashid and Dr. Sharma. Dr. Sharma reported that he had the same experience as I had—he looked for vaccination teams and couldn't find them, and the supervisor had turned off his phone. Dr. Rashid said to Dr. Sharma and I, "This situation is new for you, but I have to deal with it constantly."

We moved on to the meeting itself, which was held in the office of Farooq Sahib, the local government health administrator. Nine government supervisors, Dr. Rashid, Dr. Sharma and I all sat gingerly on new furniture encased in pristine plastic. The meeting mostly consisted of homilies from Farooq, who wore a sharp dark suit with a red tie, on

topics ranging from the importance of caring for one's parents to the brilliance of God as reflected in the flowers on his desk.

In the brief part of the meeting touching on vaccination coverage, every supervisor gave glowingly positive reports. The numbers of vaccinated children were very small—just a few children per health worker—but Farooq said he was amazed by everyone's work, adding, "Work, for sure, but also enjoy life a little."

After the meeting, Dr. Rashid sighed, "It's really difficult, going to these meetings."

Farooq had gone home, and the supervisors filed into Dr. Rashid's office to fill in the WHO's campaign report form. Dr. Rashid was annoyed—there were discrepancies across the supervisors' numbers. "Look," Dr. Rashid said to the supervisors, "This isn't how it works [*Is tarah nahin yaar kaam chelrahe]."* One supervisor told Dr. Rashid just to fabricate numbers if he didn't like the ones they gave him. Dr. Rashid refused, annoyed.

Dr. Rashid was very worried about the future of his job. He was on a three month WHO posting, which was about to expire. And, he knew, "the work isn't proceeding properly." The success of this campaign, he said, was "up to us" (he, Dr. Sharma, and I)—Farooq Sahib was obviously not going to ensure accountability, so we had to find the vaccinators that weren't doing their jobs and, somehow, motivate them to work.

Case 2: Thandaganj

Thandaganj was a town in one of South Asia's poorest areas, hours over very bad roads from the nearest urban center. Many of its residents suffered from the health problems of poverty, and the area had attracted the attention of the national government and international agencies because of outbreaks of vaccine-preventable disease.

Thandaganj was a receiving ground for government doctors who had behaved abominably elsewhere. It was difficult to fire workers in the government health system—they enjoyed career protections akin to tenure. Poorly-performing doctors were punished by assigning them to an area where they and their families did not want to live.

Thandaganj was rural yet densely populated, with few amenities but over 3,000 people per square mile. The few potholed roads were choked with traffic. On the morning my colleague and I drove to the Thandaganj hospital, we were stuck in a near-complete standstill, surrounded by horse-drawn carriages, pedestrians, motorbikes, and bicycles inching their way along.

Nearly a hundred patients were waiting outside the whitewashed cement walls of the hospital when we arrived. We made our way towards the entrance through a trash-strewn courtyard. Cleaning the building and grounds, we were told by the hospital staff who greeted us, had been "outsourced," but the work was never carried out, because the officials involved pocketed the money allocated for cleaning.

We went inside. Dr. Vinod, the government doctor in charge of the hospital, had painted the hours he worked on the wall beside his office: 12-1 and 4-5. The door was partly open. We greeted him from the doorway, which led Dr. Vinod to brusquely tell a staff member to shut the door, but not before we saw the teetering stacks of 500 rupee notes piled on the desk in front of him.

Staff and patients told us that Dr. Vinod was demanding money from Caesarian patients—from 4,000 to 6,000 rupees (up to $100) for a procedure that was supposed to be free. In cases where the woman's life was in danger, impoverished rural families would scramble to get loans from relatives and neighbors to pay the bribe.

Seeing that we had been shut out by Dr. Vinod, a local WHO employee named Raj greeted us warmly, and invited us to accompany him on his tasks for the day. Raj had a tall and stocky build, and walked vigorously to the sites he was monitoring. He was frustrated with the work in this area. "I report all kinds of problems," he said, "but nothing is ever done about them because of nepotism." The female community health workers, he said, had family connections to the clerks at the primary health center, so the clerks were not forwarding Raj's complaints about their performance. But the cold chain manager, Raj said, was the man at the center of the corrupt system.

Thandaganj was connected to the grid, but the flow of electricity could be unreliable, putting heat sensitive vaccines at risk of spoiling. Thus the cold chain system included freezers; generators in case of electricity failure; petrol for the generators; small coolers to carry vaccines door-to-door; and a supply of ice for the vaccine carriers.

The Cold Chain Room, in an outbuilding behind the hospital, was not confidence-inspiring. It contained six freezers, five of which were broken. The one operational freezer was empty save for three small boxes of vaccine, not nearly enough to serve this busy health center. The two staff members who hovered anxiously as we looked around explained that there was not space for all of the vaccine stores at the hospital, so they kept vaccines at the local ice factory and brought vials to the health center as needed.

We asked for directions to the ice factory. Only one person would say they knew where it was, and they sent us in the wrong direction. We eventually circled around and found the large multistory cement building. Being winter, a time of year when nobody wanted to buy ice, it was closed. A group of men standing outside told us that vaccines weren't stored there, but to try the ice *cream* factory.

The ice cream factory was a three-sided structure that contained some goats, a cow tethered next to a pile of hay, and a generator powering an underground freezer. The man who greeted us helpfully opened up the stone lid of the freezer so that we could see the ice packs and boxes of vaccine, kept cold at something close to the correct temperature.

We asked the man who welcomed us in if he was paid for keeping these vaccines. "It's my brother that does the business with the health center," he said, "but yes, of course there is a fee."

There was an official system for keeping vaccines outside the health post in case of freezer failure. A low-level health post employee explained:

> We receive complaints [that the cold chain is not working properly]. The biggest reason for this is that the generators have been outsourced. The government will pay 123 rupees (about $2) per hour to outsource the cold chain if there is a loss of electricity. But the people who get the outsourcing money, they don't run their generators all the time. They say they do, but they will only run it for 2 or 3 hours during the day. So there are lots of loopholes in the cold chain, and the vaccine doesn't always stay cold.
>
> Sometimes we pay out 40 to 50 thousand rupees (around $600) a month for outsourcing the cold chain. But really, we don't need to outsource. Fifteen years back, every health post got a generator from UNICEF. If the government paid one person to maintain them, they could keep things running at a fraction of the current cost.

In fact, this was the cold chain manager's job. Maintaining the regular cold chain would have required a relatively small amount of work, most of it routine and uninteresting.

Maintaining the cold chain in the ice cream factory required a lot more coordination, with the people running the ice cream factory; with the people tasked with delivering the vaccines back and forth from the factory while still keeping them cold; and with supervisors who might question why the center's refrigerators were chronically broken.

While kickbacks were the motivation for running this project, the managers of this minor scam had to work for their money.

The Corruption Game

In the vaccination programs described here, the long history of paper-mediated corruption in South Asian bureaucracies met the intense focus of global health agencies on metrics of vaccination coverage (Coutinho, Bisht, and Raje 2000). Data collected by low-level vaccination staff on paper tally sheets and vaccination registers was collated, compared with targets drawn from paper population registers and paper maps, and analyzed by UN and government staff at the national level.

Pressure to meet targets could, depending on the program and the area, be quite intense, and paper documentation was central to this system of accountability. For example, at a national-level immunization meeting in one study country, a government immunization manager from a remote area claimed that he could not vaccinate children because the federal government had failed to release immunization funding to his area. In a voice shaking with emotion, he proclaimed: "There are resources in this country… but there is no sense of responsibility, no sense of commitment, no sense of ownership!"

At this point, a high-level federal official, sounding tired, cut him off and promised to follow up on the issue, but then added:

> We keep sending you funding, we keep sending you vaccines, you don't give back any report. So it can't be one way traffic… you have to be accountable to us. What are you doing? How much vaccine did you get? How much do you need? How much did you use? How much was wasted?

In this exchange, because his paperwork was not in order, the regional manager's accusation of mismanagement at the federal level boomeranged back on him.

Districts not meeting globally determined cutoffs on specific metrics were highlighted as poorly performing in national reports. To avoid shaming and scrutiny, managers in such districts became experts at finding ways to make sure the data they submitted met national standards. In a game of metrics cat-and-mouse, international agencies and national governments found new ways to evaluate vaccination coverage and data quality (Mushtaq et al. 2010; Cutts, Izurieta, and Rhoda 2013); at times, district management found new ways to use those systems to their advantage.

Both Kashif in Nakshapur and the cold chain operator in Thandaganj diverted money into their own pockets by gaming the very paperwork designed to ensure transparency. The scam devised in Nakshapur involved the creation of maps, lists of workers who would cover the nonexistent populations on those maps, and supervisory documents evaluating the vaccination coverage in these imaginary populations. Only when all that paperwork was submitted could Kashif collect and pocket the small per diems meant to pay the nonexistent workers. As Anuradha Sharma writes, "in India and elsewhere, corruption exists not because there are insufficient laws and rules but because of their teeming overabundance" (Sharma 2018, S73).

Paperwork and Power

Prominent anthropologists from Weber to Graeber have assumed that bureaucracies support the power of those at the bureaucracy's apex. In South Asia, at least, the reality is more complicated. Jeffrey Witsoe shows that in Bihar, India, despite the fiction

of a rational bureaucracy, corruption functions to deepen the power of local elites (Witsoe 2011).

Foreign agencies and national governments have some degree of control over the bureaucratic functions of district level health systems. But this doesn't mean that the bureaucracy is functioning according to their wishes. South Asian health systems are the site of a complex game with many players, some collaborating, some competing, whose aims may be the stated goals of the bureaucracy only incidentally (cf. Hull 2012; Gupta 2012). This analysis is commonsense to South Asians, at levels from clinic patient to UN official. In Pakistan, our interviewees used the English metaphor of "blocked channels" as a shorthand for bureaucracies that fail to carry out their stated tasks.

Much of the discussion of data in medical anthropology, in addition to showing how health data is messy and politically constructed (Oni-Orisan 2016; C. Wendland 2016), focuses on the ways in which the creation and deployment of health data supports the power of technocratic regimes (Tichenor 2017; Fan and Uretsky 2017; Lorway 2017; Erikson 2012). Both of these dynamics were at play in the vaccination programs described here.

Yet close ethnographic attention to the collection and use of data, and particularly to corruption, suggests that the social life of data is often yet more complex than these arguments would suggest. In South Asian vaccination systems, data collection practices were sites of complex—and creative—moneymaking and exchange systems.

Rules for collecting and reporting data formed the playing ground for a sophisticated game. Workers and officials at the ground level created, manipulated, and

deployed data in complex ways not only to make the numbers look better, but also to divert vaccination funding into their own pockets.

And the technocrats did not always hold the upper hand. The embattled WHO head of Pakistan's polio eradication program told a journalist that he preferred working with no bureaucracy at all than the ones he had found in Pakistan: "In Somalia, there is no system, here there is a system that is against you… The polio programme has been going on for sixteen years and it had been going on for so long that it had become its own enemy, and it created its own mafia" (Abraham 2018, 190, 207).

Corruption and Anti-Corruption Revisited

The government, WHO, and UNICEF officials at the national and international level in immunization programs were under pressure to present numbers that would entice donors to keep giving. Pressure to show progress and "value for money" to donors meant that these high-level officials, like those in other donor-funded global health programs, sometimes presented the ostensibly high coverage numbers provided by districts to donors as evidence that their programs were working (Storeng and Béhague 2017; Closser 2010). In their day-to-day work, however, high-level officials, committed to increasing vaccination coverage, contested these numbers.

These officials were well aware that their systems were being gamed. For example, in one country, population estimates were a common point of contention between national-level and district-level officials. The latest census provided a count of the number of children in every district, but districts' reports of the number of children immunized exceeded these numbers by as much as 20%. There was broad consensus that the census

was an under-count, but there was also broad consensus that Kashif's practice of creating imaginary children was widespread.

In general, UN officials were concerned about such issues because they made it harder to know the true degree of immunization coverage, not because they were evidence of corruption. One high-level WHO official commented that small-scale corruption wasn't worth getting worked up about as long as vaccines were being delivered effectively, since it diverted only a small percentage of overall funding.

Because they were aware that data was being manipulated, national-level officials also gained insight into immunization coverage through other means. Vaccine-preventable disease cases were detected through surveillance systems that were partially or entirely staffed by WHO employees—if large numbers of polio or measles cases were showing up in a district, one could reasonably conclude that vaccination rates were not truly high. And, UN agencies relied on the observations and experience of their own staff in monitoring and verifying immunization.

In districts where these cross-checking measures showed excellent vaccination coverage, UN officials did not generally consider it appropriate or productive to chase after data irregularities that might reflect corrupt practices. For example, a national-level WHO official referred to the immunization manager of one district as the "head of the mafia" but also "one of the best"—rates of vaccine preventable disease in that area were very low. With ongoing outbreaks in other parts of the country, that district was not a focus of national attention.

When immunization coverage was not truly high (regardless of what the official numbers said), national- and international-level officials were left in a bind. Officials

couldn't stop giving resources entirely to districts with poor results; global initiatives to eliminate polio and measles meant that they were responsible for increasing vaccine coverage *everywhere*. So bad performance didn't lead to less resources in a district; rather, it lead to more UN consultants who aimed to work around, through, or with government staff. At the time I was in Thandaganj, there were over 100 UN staff in the district, ranging from surveillance data-crunchers to local women hired to encourage their neighbors to vaccinate.

Creative Bureaucracies

Because the exercise of UN power was aimed not at ending corruption but at vaccinating children, the space that corrupt practices occupied in vaccination programs in South Asia was not quite an inverted mirror of the regulations, but a creative, sprawling offshoot of them. Data procedures and paperwork formed the rules and the playing board for a complex game in the spaces created by aid money.

Some sophisticated staff gamed paperwork to make money; in turn, other staff navigated around and through corrupt practices in an attempt to ensure children were immunized. Some particularly skilled operators achieved both of these ends simultaneously, making money for themselves while also ensuring high vaccination coverage. Rather than a Weberian bureaucracy that supported the power of technocrats, South Asian immunization systems were the site of a sophisticated game with many players, whose aims were more complex than the stated goals of the bureaucracy.

The thin-ness of the medical anthropological literature on corruption may be in part due to anthropologists' reluctance to contribute to tired tropes about local corruption and

failed aid projects. But corruption is worth paying attention to for analytic reasons: it has real effects on the structure and implementation of health aid programs at multiple levels. The shape of its influence depends on the context. At international levels, corporate money and power can hold powerful sway, as in the debate over infant formula at the WHO (Jacobs 2018). On the ground in South Asia, practices of corruption are shaped both by colonial legacies, and by distinctly modern flows of money and accountability.

Corruption is a small but important part of the politics and power relations of health systems across the world. Understanding it more fully can facilitate more complex and informed analyses of how power, money, and data interact in global health programs. A voluminous medical anthropological literature on corruption is likely unnecessary; it already gets too much blame in popular discourse for poor service provision in settings of poverty. But neither should it be ignored or soft-pedaled. The complex corruption game is a critical part of the system of service delivery—reason enough for medical anthropologists to look it straight in the eye.

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